AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INCOMPLETED (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETED)	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					PRINTED: 06/22/2013 FORM APPROVED OMB NO. 0938-039	
NAME OF PROVIDER OR SUPPLIER ISLAND HOME PARK HEALTH AND REHAB (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS Complaint investigation #29896 and #29937 were completed on June 18-20, 2012. No deficiencies were cited under 42 CFR Part 483	1 100000		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	80 AND DESCRIPTION OF THE PROPERTY OF THE PROP		(X3) DATE SURVEY	
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were completed on June 18-20, 2012. No deficiencies were cited under 42 CFR Part 483	F 000	INITIAL COMMEN	ITS	F 000			
		were completed or deficiencies were	1 June 18-20, 2012. No Cited under 42 CFR Part 483				
BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE:	BORATORY	DIRECTOR'S OR PROVID	DED/SUDDINED DEDDESCRITATIVES OF				(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

(X6) DATE